# BENEFITS AT A GLANCE

**This section of *Your King County Benefits* highlights the major features of your benefits for easy reference. More detailed information is available in the individual plan sections.**

## In This Section — See Page

# HEALTH CARE

As a King County employee who's eligible for benefits, you receive medical (including prescription drug), dental and vision coverage for yourself and the eligible dependents (spouse/domestic partner and dependent children) you enroll.

## Participating in the Health Care Plans

To effectively use the health care plans, you need to know who's eligible for coverage, when and how to enroll, when you can make changes, who pays for coverage, when coverage begins and ends, and when you can continue coverage.

### Who's Eligible

You're eligible for county-paid medical, dental and vision coverage for yourself and the eligible dependents (spouse/domestic partner and dependent children) you enroll if you're:

- a regular part-time or full-time employee;
- a full-time Local 587 employee; or
- an employee in a provisional or term-limited temporary position (your hiring authority can tell you if your position is benefit-eligible).

A regular part-time employee is someone who works at least half-time but less than full-time in a calendar year.

### When and How to Enroll

You receive benefit enrollment forms in your Regular Employee New Hire Guide and wellness assessments for you and your spouse/domestic partner when you attend a new employee orientation after you first report to work.

To enroll in your health care plans, you must return the benefit enrollment forms in your Regular Employee New Hire Guide to Benefits and Retirement Operations **within 30 days of your hire date,** which is the first day you report to work. If you don't meet this deadline:

- you'll be assigned KingCare℠ as your default medical coverage at the out-of-pocket expense level you and your spouse/domestic partner achieve by taking or not taking the wellness assessment within 14 days of the new employee orientation;
- you won't be able to enroll your dependents for any health care coverage—medical, dental or vision—until you have a qualifying life event or enroll them during the next annual open enrollment; and
- you won't be able to change your medical plan until the next annual open enrollment.

**FOR MORE INFORMATION**

**For more detailed information about participating in King County's health care plans, see "Participating in the Health Care Plans" in *Health Care*.**

In addition to returning your enrollment forms, you and your spouse/domestic partner must each decide whether to take the wellness assessment and must return it **within 14 days of attending your new employee orientation.**

If you don't enroll when you're first eligible, you may enroll yourself and your eligible dependents during the annual open enrollment.

## When You Can Change Coverage

You may make certain changes to your health care coverage during the county's annual open enrollment and after certain qualifying life events—for example, you may add an eligible dependent if you get married or have a child.

In addition, you may discontinue coverage for your eligible dependents at any time.

## Who Pays for Coverage

Because you're a benefit-eligible employee, the county pays the entire premium for medical, dental and vision coverage for you and the eligible dependents you enroll. However, you pay a benefit access fee of $35 a month if you cover a spouse/domestic partner who has access to medical care coverage through an employer other than King County, a union trust paid by an employer, or the military while in active duty status.

## When Coverage Begins

If you're eligible for benefits, your medical, dental and vision coverage begins on the first day of the month following your hire date, which is the day you first report to work, unless modified by your collective bargaining agreement. If your hire date is the first day of the month, your coverage begins the same day.

If you're hospitalized under another benefit plan and you're in the hospital on the day county coverage would normally begin, the other plan usually continues to provide your coverage until you're discharged.

When you change coverage during the annual open enrollment, your new coverage begins January 1 of the following year and stays in effect for the entire calendar year, as long as you remain eligible.

When you return from an unpaid leave of absence, your coverage resumes on the first day of the month following your return. If you return on the first calendar day of the month, your coverage resumes the same day.

## When You Can Change Coverage

You may make certain changes to your health care coverage during the county's annual open enrollment and after certain qualifying life events—for example, you may add an eligible dependent if you get married or have a child.

You must discontinue health care coverage for a dependent who is no longer eligible, such as a child who turns 23.

There are a number of changes you may make to your health care coverage at any time: you may discontinue coverage for your eligible dependents, and you may discontinue or reduce coverage you pay for.

### When Coverage Ends

Your health care coverage ends on:

- the last day of the month you lose eligibility, resign, are terminated, retire or die; or
- the day the plan terminates.

Health care coverage for your covered dependents ends on:

- the last day of the month they lose eligibility, your coverage ends or they die; or
- the day the plan terminates.

### How to Continue Coverage

If you or your eligible dependents lose county-paid health care coverage due to certain qualifying life events, each of you has an independent right to continue medical, dental and vision coverage through COBRA (Consolidated Omnibus Budget Reconciliation Act). This coverage, which is entirely paid by you, may continue for 18 to 36 months after county-paid coverage ends.

## Medical Plans

The county offers benefit-eligible employees a choice between two medical plans:

- KingCare℠, a preferred provider plan; and
- Group Health, a health maintenance organization.

### How KingCare℠ Works

When you're enrolled in KingCare℠, you may receive benefits from network or out-of-network providers. The level of benefits you receive depends on the provider you choose. You pay less when you go to network providers than when you see providers who aren't part of the network.

When you go to network providers, you first pay an annual deductible; after that you pay coinsurance on a portion of the contracted cost.

Reimbursement for out-of-network medical care is based on reasonable and customary (R&C) rates. You pay the annual deductible, the coinsurance and any amounts over R&C rates.

You may purchase prescription drugs at retail pharmacies or through the mail-order service.

**FOR MORE INFORMATION**

**For more information about how the county's medical plans work, see "KingCare℠" and "Group Health" in *Health Care*.**

Medical benefits under KingCare[SM] are administered by Aetna. Prescription benefits under the plan are administered by Express Scripts. You receive a medical ID card from Aetna for your medical coverage and a separate ID card from Express Scripts for your prescription drug coverage.

### How to File a Claim

If you receive care from Aetna network providers, they submit claims for you. If you receive care from an out-of-network provider, your provider may submit a claim for you, or you may have to pay the provider in full and submit a claim to Aetna for reimbursement of R&C charges.

When you go to an Express Scripts network pharmacy, there's no claim to file. However, if you fill a prescription at an out-of-network pharmacy, you're responsible for paying the pharmacy in full and submitting a claim to Express Scripts, which will reimburse you at the negotiated rate within its network.

## How Group Health Works

When you're enrolled in Group Health, you'll receive benefits if you see your primary care physician or another provider within the Group Health network. If you see a provider who isn't part of the network, you'll receive benefits only if you need emergency care or your network provider refers you to an out-of-network provider.

When you receive care from a network provider, you pay a flat amount, called a copay, at the time you receive health care services or fill prescriptions. After the copay, Group Health pays 100% for most covered services and supplies.

Medical and prescription drug benefits under Group Health are administered by Group Health. You receive a single ID card from Group Health for both your medical and prescription drug coverage.

### How to File a Claim

If you receive care from a network provider, the provider submits claims for you. If you receive emergency services from an out-of-network provider, you pay the provider in full, and it's your responsibility to submit a claim form to Group Health or have the provider submit one for you.

# Dental Plan

The county offers benefit-eligible employees a dental plan through Washington Dental Service (WDS), a member of the Delta Dental Plans Association.

## How the Dental Plan Works

When you're enrolled in the dental plan, you may receive benefits from WDS/Delta Dental participating dentists or from non-participating dentists. The level of benefits you receive depends on the dentist you choose. You usually pay less when you go to a WDS/Delta Dental participating dentist than when you see a non-participating dentist.

**FOR MORE INFORMATION**

**For more information about how the dental plan works, see "Dental Plan" in *Health Care*.**

When you go to a WDS/Delta Dental participating dentist, you first pay an annual deductible, if applicable; then you pay coinsurance based on the rates that WDS pays participating dentists. When you go to a non-participating dentist, WDS reimburses you based on what it pays WDS/Delta Dental participating dentists, and you're responsible for paying any remaining amount.

You don't receive an ID card for your dental plan. You'll need to tell your dentist you're covered by the WDS plan for King County. You must provide the plan's group number (00152) and either your Social Security number or a unique identifier (if you've requested one) for verification of your benefit eligibility.

### How to File a Claim

If you receive care from a WDS/Delta Dental participating dentist, the dentist submits claims for you and obtains any necessary predetermination for certain procedures and services.

If you receive care from a non-participating dentist, your provider may submit claims for you, or you may have to pay the dentist in full and submit a claim to WDS for reimbursement. In addition, you must obtain predetermination from WDS for certain procedures and services.

## Vision Plan

The county offers benefit-eligible employees a vision plan through Vision Service Plan (VSP).

### How the Vision Plan Works

When you're enrolled in the vision plan, you may receive eye care benefits from VSP providers or non-VSP providers. The level of benefits you receive depends on the provider you choose. You usually pay less when you go to a VSP provider than when you see a non-VSP provider.

When you go to a VSP provider, you pay a $10 copay when you meet with the provider, and the plan pays 100% for most covered services. When you go to a non-VSP provider, you'll pay the bill in full, and VSP will reimburse you up to the plan allowance for each service, minus a $10 copay.

You don't receive an ID card for your vision plan. You'll need to tell your eye care provider you're covered by the VSP plan for King County. You must provide the employee's Social Security number (or alternate ID if one has been requested) for verification of your eligibility.

### How to File a Claim

If you receive care from a VSP provider, the provider will handle all your claims.

If you receive care from a non-VSP provider, you'll have to submit claims to VSP for reimbursement.

**FOR MORE INFORMATION**

**For more information about how the vision plan works, see "Vision Plan" in *Health Care*.**

# Flexible Spending Accounts

As a King County employee who's eligible for benefits, you may be eligible to enroll in either a health care flexible spending account (FSA) or a dependent care FSA, or both.

## Participating in FSAs

To effectively use FSAs, you need to know who's eligible to participate, when and how to enroll, when you can make changes, when participation begins and ends, and when you can continue participation.

**FOR MORE INFORMATION**

**For more detailed information about participating in FSAs, see "Participating in FSAs" in *Flexible Spending Accounts*.**

### Who's Eligible

You're eligible to participate in an FSA when you first become eligible for benefits, have a qualifying life event or enroll in an FSA during the annual open enrollment.

You're eligible for benefits if you're:

- a regular part-time or full-time employee;
- a full-time Local 587 employee; or
- an employee in a provisional or term-limited temporary position (your hiring authority can tell you if your position is benefit-eligible).

A regular part-time employee is someone who works at least half-time but less than full-time in a calendar year.

### When and How to Enroll

You receive FSA information and a Flexible Spending Account Enrollment form when you first become eligible for benefits. You must return your enrollment form to Benefits and Retirement Operations within 30 days of your benefit-eligibility date. Your benefit-eligibility date is the day you first report to work.

During the annual open enrollment, you make your FSA election online for the following calendar year. You must re-enroll each year if you want to continue participating in an FSA the following year.

### When and How You Can Change Participation

The election you make when you enroll in an FSA remains in effect for the entire calendar year. The only times you can change your elections—either begin, increase, decrease or stop contributions to an FSA—are:

- during the annual open enrollment for the following calendar year; and
- when you have a qualifying life event in the current calendar year.

To modify your FSA election when you have a qualifying life event, you must complete an online form within 30 days of the date of the qualifying life event.

## When Participation Begins

The date your FSA begins depends on when you enroll:

- If you enroll in an FSA when you first become eligible for benefits, your FSA begins on the day your benefits begin, and you begin making contributions to your account through payroll deduction for the remainder of the calendar year. If you begin work on the first day of the month, your FSA begins on that day. If you begin work on any other day of the month, your FSA begins on the first day of the following month.
- If you enroll in an FSA because of a qualifying life event, your FSA becomes effective on the first day of the month following your qualifying life event and continues through the end of the calendar year. The amount you contribute to your account will be adjusted for the remaining payroll periods in the calendar year.

If you enroll online in an FSA during the annual open enrollment, you begin making contributions to your account with every paycheck in the next calendar year. Your FSA participation continues through December 31 of that calendar year.

## When Participation Ends

Your participation in an FSA ends when you leave employment with the county and don't continue your benefits coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act) or the retiree medical benefit.

However, when you take a leave of absence without pay and don't continue your benefits coverage, your participation is suspended temporarily until you return to work in a paid status. At that time, your participation will be resumed as long as your paycheck is large enough to cover the remaining deductions.

## How to Continue Participation

You can continue participation in your health care and/or dependent care FSA when you:

- leave employment with the county;
- go on a leave of absence under the Family and Medical Leave Act (FMLA); or
- go on an unpaid leave of absence.

# FSAs

King County offers two FSAs for all benefit-eligible employees:

- a **health care FSA**, which allows you to use before-tax dollars to pay for certain eligible expenses not covered by your medical, dental and vision plans (for example, copays for office visits, and the cost of orthodontia not fully paid by your dental plan); and
- a **dependent care FSA**, which allows you to use before-tax dollars to pay for eligible dependent day care expenses for your child, disabled spouse or other disabled dependents while you and your spouse work or look for work.

## How FSAs Work

When you put money into an FSA, you don't pay federal income or Social Security (FICA) taxes on it. As a result, your taxable income is reduced and your taxes are lower.

When you decide to enroll in an FSA, it's very important that you estimate your eligible expenses as accurately as possible. The county allows you to be reimbursed only for expenses incurred in the calendar year of your FSA. You may request reimbursement from an FSA through March 31 of the following year for eligible expenses incurred during the calendar year. However, if FBMC, the FSA third-party administrator, doesn't receive your request by March 31, any funds left in your FSA after March 31 are forfeited, as required by IRS regulations.

Because health care and dependent care FSAs are separate accounts, the funds you allocate for one can't be used for the other, and you can't transfer dollars between accounts.

## Health Care FSA

The minimum amount you may set aside for a health care FSA to pay for eligible expenses is $300, and the maximum amount is $6,000.

In general, health care expenses that would be deductible on your federal income tax return, excluding long-term care expenses, are eligible for reimbursement through the health care FSA.

**FOR MORE INFORMATION**

**For more information about how FSAs work, see "An Overview of FSAs" in *Flexible Spending Accounts*.**

**FOR MORE INFORMATION**

**For more information about how health care FSAs work, see "How the Health Care FSA Works" in *Flexible Spending Accounts*.**

## Dependent Care FSA

The minimum amount you may contribute to a dependent care FSA is $300 per calendar year. The maximum amount you may contribute depends on your family situation, but the amount can't exceed $5,000.

To qualify for reimbursements from a dependent care FSA, you and your spouse must be at work or looking for work while your eligible dependents receive care. You must also meet certain eligibility requirements.

**FOR MORE INFORMATION**

**For more information about how dependent care FSAs work, see "How the Dependent Care FSA Works" in *Flexible Spending Accounts*.**

## How to File a Claim

### Health Care FSA

With a health care FSA, you may begin getting reimbursed from the FSA as soon as you incur eligible expenses in the FSA calendar year and your health care FSA reimbursement request has been received and approved. You're reimbursed for eligible expenses up to the maximum amount you elected, minus any previous reimbursements made during the calendar year.

### Dependent Care FSA

With a dependent care FSA, you can get reimbursed for eligible expenses from the FSA only for amounts that are currently in your account. When future contributions are made to your account, you automatically receive another reimbursement until your total claim amount has been reimbursed or you reach your election amount for the calendar year.

# Long-Term Disability (LTD) Insurance Plan

As a benefit-eligible employee, you receive county-paid basic long-term disability (LTD) insurance through CIGNA Group Insurance. You also have the option to purchase CIGNA supplemental LTD insurance for yourself when you first become a benefit-eligible employee with King County.

## Participating in the LTD Plan

To effectively use the LTD plan, you need to know who's eligible for the county's LTD insurance, when and how to enroll, when you can make changes, who pays for coverage, and when coverage begins and ends.

**FOR MORE INFORMATION**

**For more detailed information about participating in the LTD plan, see "Participating in the LTD Plan" in *Long-Term Disability Plan*.**

## Who's Eligible

You're eligible for county-paid basic LTD insurance if you're:

- a regular part-time or full-time employee;
- a full-time Local 587 employee; or
- an employee in a provisional or term-limited temporary position (your hiring authority can tell you if your position is benefit-eligible).

A regular part-time employee is someone who works at least half-time but less than full-time in a calendar year.

At the time you become a benefit-eligible employee (usually when you first come to work for the county), you're also eligible to purchase supplemental LTD insurance.

## When and How to Enroll

When you become eligible for benefits, you receive benefit information and enrollment forms in a Regular Employee New Hire Guide at your new employee orientation. You're automatically enrolled in the basic LTD plan. If you want to purchase supplemental LTD insurance, you must return your benefit enrollment forms to Benefits and Retirement Operations within 31 days after the date your benefits begin.

If you don't purchase supplemental LTD insurance when you're first eligible, there are limited opportunities to purchase coverage later.

## When and How You Can Change Coverage

The only change you can make to your LTD insurance is to discontinue supplemental LTD insurance, and you can discontinue coverage at any time. The reason you may discontinue supplemental LTD insurance is because you're paying for it.

If you wish to discontinue your supplemental LTD insurance, you need to submit a written request to Benefits and Retirement Operations or e-mail a request to kc.benefits@metrokc.gov.

## Who Pays for Coverage

Because you're a regular employee, your basic LTD insurance is paid by the county.

If you elect supplemental LTD insurance, you pay a monthly premium based on your covered earnings up to a maximum of $12,000 a month. You pay your monthly premiums through payroll deduction.

The cost of supplemental LTD insurance depends on your base annual salary. Annually, you pay $.19 per $100 of salary.

## When Coverage Begins

Coverage begins the first day of the month following your hire date, which is the first day you report to work, unless modified by your collective bargaining agreement. If your hire date is the first day of the month, your coverage begins the same day.

## When Coverage Ends

Your coverage ends on:

- the last day of the month in which you lose eligibility, resign, are terminated, retire, fail to make any required payments for self-paid coverage or die; or
- the day the plan terminates.

# LTD Plan

The LTD plan pays you a portion of your income when you're unable to work due to a disability.

## How the LTD Plan Works

You become eligible for LTD benefits when you meet the plan's definition of "disability." Disability occurs if, because of injury or illness, you're unable to perform all the material duties of your regular occupation, and if solely due to injury or sickness, you're unable to earn more than 80% of your indexed covered earnings from working in your regular occupation. After 24 months, you're considered disabled if you're unable to perform all the material duties of any occupation, and if solely due to injury or sickness, you're unable to earn more than 80% of your indexed covered earnings from working in any occupation.

## How Benefits Are Calculated

CIGNA will calculate your LTD benefit based on your earnings on the last day you worked, as well as on other sources of income, such as workers' compensation, you're receiving at that time.

### Basic LTD Insurance

Basic LTD insurance provides up to a total of 60% of all your predisability earnings after a 180-day benefit waiting period. If you return to work during or after your disability, the benefit can be as much as 100%. The maximum monthly benefit is $6,000.

### Supplemental LTD Insurance

Supplemental LTD insurance provides up to a total of 60% of all your predisability earnings after a 90-day benefit waiting period. If you return to work during or after your disability, the benefit amount can be as much as 100%. The maximum monthly benefit is $7,200.

## How Benefits Are Paid

After CIGNA receives and accepts proof of your disability, benefits are paid monthly. If you're not disabled for a complete month, an amount equal to $^{1}/_{30}$ of the LTD benefit is payable for each day that you're disabled.

**FOR MORE INFORMATION**

**For more detailed information about how the LTD plan works, see "The LTD Plan" in *Long-Term Disability Plan*.**

**IMPORTANT!**

**Certain limitations and exclusions may limit LTD benefits. (For more information about benefit limitations and exclusions, see "Understanding Exclusions and Limitations" in "The LTD Plan" in *Long-Term Disability Plan*.)**

## How to File a Claim

If you're disabled and it seems likely your disability will last for the duration of the benefit waiting period, contact CIGNA by phone or through its Web site. You can submit a claim by phone or mail, or online. CIGNA must approve your claim before it is payable.

# Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance Plans

As a benefit-eligible employee, you receive county-paid basic life insurance through Aetna Life Insurance and basic accidental death and dismemberment (AD&D) insurance through CIGNA Group Insurance. You have the option to purchase supplemental life insurance and supplemental AD&D insurance for you and your eligible dependents.

## Participating in the Life Insurance and AD&D Insurance Plans

**FOR MORE INFORMATION**

**For more detailed information about participating in the life and AD&D plans, see "Participating in the Life and Accident Plans" in *Life and Accident Protection*.**

To effectively use your life and AD&D insurance plans, you need to know who's eligible for the county's life and AD&D insurance, when and how to enroll, when you can make changes, who pays for coverage, and when coverage begins and ends.

### Who's Eligible

You're eligible for county-paid basic life and AD&D insurance if you're:

- a regular part-time or full-time employee;
- a full-time Local 587 employee; or
- an employee in a provisional or term-limited temporary position (your hiring authority can tell you if your position is benefit-eligible).

A regular part-time employee is someone who works at least half-time but less than full-time in a calendar year.

### When and How to Enroll

When you become eligible for benefits, you receive benefit information and enrollment forms in a Regular Employee New Hire Guide at your new employee orientation. You're automatically enrolled in the basic life and AD&D plans. If you want to purchase supplemental life and supplemental AD&D insurance, you must return your benefit enrollment forms to Benefits and Retirement Operations within 31 days after the date your benefits begin. If you don't purchase supplemental life insurance when you're first eligible, you'll have limited opportunities to purchase coverage later on.

## When and How You Can Change Coverage

When you have a qualifying life event, you may add, increase, decrease or drop supplemental life and supplemental AD&D insurance for you and your eligible dependents. However, you may add supplemental life and supplemental AD&D insurance for your eligible dependents only if you already have supplemental insurance for yourself.

The only change you can make at any time to supplemental life and supplemental AD&D insurance is to drop or decrease coverage—that's because you're paying for it.

To add or change supplemental life and supplemental AD&D insurance after a qualifying event, you must complete the appropriate form online within 31 days after the date your benefits begin.

If you wish to drop your supplemental life and/or supplemental AD&D insurance, you need to submit a written request to Benefits and Retirement Operations or e-mail your request to kc.benefits@metrokc.gov.

## Who Pays for Coverage

If you're benefit-eligible, the county pays for your basic life and AD&D insurance; you pay for any supplemental insurance you purchase for you and your eligible dependents.

If you're benefit-eligible and on an unpaid leave of absence, you may pay for basic life and AD&D insurance, as well as any supplemental insurance you already have.

## When Coverage Begins

Coverage begins on the first day of the month following your hire date, unless modified by your collective bargaining agreement. If your hire date is the first day of the month, your coverage begins the same day.

## When Coverage Ends

Coverage ends on:

- the last day of the month you lose eligibility, resign, are terminated, retire, fail to make any required payments for self-paid coverage or die; or
- the day the plan terminates.

Your covered dependent's life and AD&D insurance also ends on the last day of the month your covered dependent enters into active full-time military service.

## How to Continue or Convert Coverage

When you leave county employment, you may want to know your options for continuing and/or converting your life and AD&D insurance coverage.

### Life Insurance

When you leave county employment for reasons other than disability, you may continue your existing life insurance or convert it to a whole life policy.

### AD&D Insurance

Your AD&D insurance isn't portable. However, you may be eligible to purchase AD&D conversion insurance with CIGNA under certain circumstances.

## Life Insurance Plan

Life insurance offers you and your family financial protection if a covered family member dies. You may also purchase supplemental life insurance for you and your eligible dependents to increase your coverage.

**FOR MORE INFORMATION**

**For more detailed information about how the life insurance plan works, see "Life Insurance Plan" in *Life and Accident Protection*.**

### How the Life Insurance Plan Works

The life insurance plan includes:

- basic life insurance, which the county provides to benefit-eligible employees at no cost; and
- supplemental life insurance, which enables you to purchase additional coverage for you and your eligible family members.

If you elect supplemental life insurance for yourself and you die, your beneficiaries receive a benefit equal to the supplemental amount you've purchased **plus** your county-paid basic life insurance. If you elect supplemental life insurance for your eligible dependents, you're the beneficiary of supplemental life insurance if one of your covered dependents dies.

### How Benefits Are Calculated

The amount of life insurance benefit you or your beneficiaries receive is based on your basic life insurance and, if you elected it, your supplemental life insurance.

#### Basic Life Insurance

As a regular employee, you receive county-paid basic life insurance. Your basic life insurance is based on your base annual salary, which is your base pay excluding overtime, bonuses, shift differential, premium pay or any other special pay. The maximum basic life insurance you may have is $200,000. If you die, your beneficiaries receive a benefit equal to your base annual salary, rounded up to the next $1,000.

#### Supplemental Life Insurance

You may purchase supplemental life insurance for yourself equal to 1, 2, 3 or 4 times your base annual salary, rounded up to the next $1,000, without evidence of insurability (EOI). The maximum supplemental life insurance coverage you may purchase is $400,000.

If you elect supplemental life insurance for yourself, you may purchase:

- 50% of the amount of your supplemental life insurance (up to $100,000 without EOI or up to $200,000 with EOI) for your spouse/domestic partner; and
- $10,000 for each eligible child age 6 months to 23 years, and $500 for each eligible child age 14 days to 6 months. If you cover one child, all children are covered. EOI isn't required.

### How Benefits Are Paid

Life insurance benefits can be paid at your death or the death of a covered dependent. Insurance is paid in a lump sum and isn't subject to federal income tax.

In the case of your or your covered spouse/domestic partner's terminal illness, certain benefits may be paid to you before death.

## How to File a Claim

For a death or accelerated claim, you or your beneficiary should contact Aetna to file a claim. Benefits and Retirement Operations staff will help file the claim with Aetna, and provide referrals to counseling and other resources as requested.

# AD&D Insurance Plan

The accidental death and dismemberment (AD&D) insurance plan pays benefits if you or a covered family member dies or suffers a specified dismemberment, paralysis and other loss that occurs within 365 days of a covered accident.

## How the AD&D Insurance Plan Works

The plan includes:

- basic AD&D insurance, which the county provides to benefit-eligible employees at no cost; and
- supplemental AD&D insurance, which enables you to purchase additional coverage for yourself only or coverage for you and your family.

If you elect supplemental AD&D insurance for yourself and you die as the result of a covered accident, your beneficiaries receive a benefit equal to the supplemental amount you've purchased **plus** your county-paid basic AD&D insurance benefit. If you elect supplemental AD&D insurance for your eligible dependents, you're the beneficiary of supplemental AD&D insurance if one of your covered dependents dies as the result of a covered accident.

## How Benefits Are Calculated

The amount of AD&D insurance benefit you or your beneficiaries receive is based on your basic AD&D insurance and, if you elected it, your supplemental AD&D insurance.

**FOR MORE INFORMATION**

**For more detailed information about how the AD&D insurance plan works, see "Accidental Death and Dismemberment (AD&D) Insurance Plan" in *Life and Accident Protection*.**

### Basic AD&D Insurance

As a regular employee, you receive county-paid basic AD&D insurance. Your basic AD&D benefit is equal to your base annual salary, rounded up to the next $1,000. Your base annual salary is your base pay excluding overtime, bonuses, shift differential, premium pay or any other special pay. The maximum basic AD&D insurance you may have is $200,000.

### Supplemental AD&D Insurance

You may purchase supplemental AD&D insurance from $50,000 to $500,000 in increments of $50,000 for yourself without evidence of insurability (EOI).

If you elect supplemental AD&D insurance for yourself, you may purchase:

- 50% or 100% of the amount of your supplemental life insurance for your spouse/domestic partner; and
- 10% of the amount of your supplemental life insurance for your eligible children.

## Other AD&D Benefits

Supplemental AD&D insurance offers some benefits in addition to accidental death and dismemberment coverage. These benefits include a brain damage benefit, child care benefit, coma benefit, education benefit, felonious assault benefit, rehabilitation benefit, seatbelt/airbag benefit, secure travel benefit, special care benefit for children, and violent crime benefit.

## How Benefits Are Paid

AD&D insurance benefits are payable if you or a covered dependent dies as the result of a covered accident. Insurance is paid in a lump sum and isn't subject to federal income tax. Be sure to consult your tax advisor for more information on taxes and death benefits.

## How to File a Claim

For a death, specified dismemberment or paralysis claim, you or your beneficiary should contact Benefits and Retirement Operations. Benefits and Retirement Operations staff will help file the claim with CIGNA and provide referrals to counseling and other resources as requested. The claim should be filed within 90 days of the loss or death.